Magnolia Health Plan | Cenpatico Improving Lives

SUBMIT TO:
Utilization Management Department
504 Lavaca, Suite 850, Austin TX 78701
866-912-6285
FAX: 866-694-3649

Electroconvulsive Therapy (ECT)

Please print clearly – incomplete or illegible forms will delay processing.

Demographics

Patient Name: _____
Health Plan: _____
DOB: _____
SSN: _____
Patient ID: _____
Last Auth #: _____

Provider Information

Provider Name (print): _____
Hospital where ECT will be performed: _____
Professional Credential: MD ☐ PhD ☐ Other _____
Physical Address: _____
(street address, city, state, zip code)
Phone: _____ Fax: _____
Medicaid/TPI/NPI #: _____ Medicaid Tax ID #: _____

Previous BH/SA Treatment

☐ **None** or ☐ **OP** ☐ MH ☐ SA and/or ☐ IP ☐ MH ☐ SA
List names and dates, include hospitalizations: _____

Substance Abuse: ☐ None ☐ By History and/or ☐ Current/Active
Substance(s) used, amount, frequency and last used: _____

DSM IV Axis:
AXIS I _____
AXIS II _____
AXIS III _____
AXIS IV _____
AXIS V _____

Requested Authorization for ECT

Please indicate type(s) of service provided **BY YOU** and the frequency):

Total sessions requested: _____
Type: _____Bilateral _____ Unilateral
Frequency: _____
Date first ECT: _____ Date last ECT: _____
Est. # of ECTs to complete treatment: _____
Requested start date for authorization: _____
Last ECT info:
Length:_____
Length of convulsion: _____

Current Risk/Lethality

Suicidal	☐ 1 NONE	☐ 2 LOW	☐ 3 MOD*	☐ 4 HIGH*	☐ 5 EXTREME*
Homicidal	☐ 1 NONE	☐ 2 LOW	☐ 3 MOD*	☐ 4 HIGH*	☐ 5 EXTREME*
Assault/ Violent Behavior	☐ 1 NONE	☐ 2 LOW	☐ 3 MOD*	☐ 4 HIGH*	☐ 5 EXTREME*
Psychotic Symptoms:	☐ 1 NONE	☐ 2 LOW	☐ 3 MOD*	☐ 4 HIGH*	☐ 5 EXTREME*

*3, 4, or 5 please describe what safety precautions are in place: _____

PMP Communication

Has information been shared with the PMP regarding Behavioral Health Provider Contact Information, Date of Initial Visit, Presenting Problem, Diagnosis, and Medications Prescribed (if applicable)?

PMP communication completed on _____ via: ☐ Phone ☐ Fax ☐ Mail
☐ Member Refused By: _____ (Signature/Title)
Coordination of care with other behavioral health providers?_____
Has informed consent been obtained from patient/guardian? _____
Date of most recent psychiatric evaluation: _____
Date of most recent physical examination and indication if an anesthesiology consult was completed: _____

Current Psychotropic Medications:

Name	Dosage	Frequency

Psychiatric/Medical History

Please indicate current acute symptoms member is experiencing:

_____

Please indicate any present or past history of medical problems including allergies, seizure history and if member is pregnant:

_____

Reason for ECT need
Please objectively define the reasons ECT is warranted including failed lower levels of care (including any medication trials):

Please indicate what education about ECT has been provided to the family and which responsible party will transport patient to ECT appointments:

ECT outcome
Please indicate progress member has made to date with ECT treatment:

ECT discontinuation
Please objectively define when ECTs will be discontinued – what changes will have occured:

Please indicate the plans for treatment and medication once ECT is completed:

Provider Name (please print) **Provider Signature** **Date**